

OHIO MEDICAID HEALTH HOMES FOR THOSE WITH SERIOUS AND  
PERSISTENT MENTAL ILLNESS

## Staffing Arrangements & Team Composition Committee

### AGENDA

*Purpose: review functions and credentials of the care manager, the supervisory structure and team requirements.*

**November 9, 2011**

**1:00 – 4:00 p.m.**

**Rhodes, Rm. 1845**

- **Welcome & Introductions**
- **Review of Purpose**
- **Review of Rhode Island and Missouri State Plan Amendments**
- **Review of Service Definitions**
- **Review of Draft Community Behavioral Health Center Health Home Team Composition Document**
- **Review of Draft Staffing Summary**
- **Next Steps**
- **Next Meeting: December 2, 2011, 1:30 – 4:30 p.m., Rhodes Rm. 1855**



**Staffing Arrangements & Team Composition Committee**  
**Meeting Minutes**  
**November 9, 2011**

**Attendees:** Kristina Allwood, Jon Barley, Angie Bergefurd, Kueiting Betts, Jack Cameron, Christy Daron, Joe Doodan, Lee Dunham, Lisa Durham, Mary Haller, Deb Hrouda, Betsy Johnson, Mark Johnson, Terry Jones, Afet Kilinc, Lynne Lyon, Jody Lynch, Kara Miller, Jen Moses, Jeff O'Neil, Frank Sepetauc, Alicia Smith, Danielle Smith, Peggy Smith, Beth Trecasa, Nancy Trux, Stephanie Weigel, Debbie Whitten

**WELCOME AND INTRODUCTION & REVIEW OF PURPOSE:**

The meeting opened and attendees introduced themselves. Ms. Bergefurd stated the purpose of the group: Staffing Arrangements & Team Composition Committee is one of the logistical groups to assist putting together a state plan amendment related to health homes for people with serious and persistent mental illness. The committee members need to define the core members of health home teams, optional members, supervisory structures, functions of different components of health home team, etc.

Ms. Bergefurd provided an overview of the Medicaid Health Homes project:

- A new service that CMS is putting for as a result of Affordable Care Act section 2703. Medicaid consumers with one serious and persistent mental health condition or two or more chronic and complex conditions, or one chronic condition and at risk for a second are eligible for the services. Cannot exclude dual eligible and cannot target specific ages.
- State is currently looking into an option that would allow community behavioral health centers the opportunity to be a health home for those with SPMI that would be meeting the core elements and be eligible for health home payments.
- Six health home services: 1) comprehensive care management, 2) care coordination, 3) health promotion, 4) transition of care, 5) individual and family supports, and 6) referrals to community and social supports. Use HIT to link services.
- Funding is a federal-state match. States contribute 10% and Feds contribute 90% of cost for first 8 quarters; then regular match after that.
- State of Ohio is planning to do the health home project on a regional basis, not statewide.
- 3 options to become a health home provider: one designated provider model and two types of team health professionals.
- State of Ohio is looking into per member per month (PMPM) reimbursement approach.

**RHODE ISLAND AND MISSOURI STATE PLAN AMENDMENTS (SPA):**

The approved SPA from Missouri and submitted SPA from Rhode Island (will be approved on 11/23/2011) were reviewed by the group.

Ms. Smith provided information on how other states address team compositions:

**Missouri State Plan Amendments (SPA):**

- Missouri is a state that has been in the integrated physical and behavioral health business from the mental health side in the past 10 years. It has been smooth for Missouri to transition to health home.
- Per SPA, CMHC Health Homes will be physician-led with health teams minimally comprised of a Health Home Director, a Health Home Primary Care Physician

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Consultant, a Nurse Care Manager(s), a Health Home Administrative support staff and other optional team members. The care coordination services (6 health home services) provided by the required team members make State generate per member per month (PMPM) payment. Centers do not get reimbursements for direct care services, i.e. treatments council, rehab, etc.

**Rhode Island State Plan Amendments (SPA):**

- Per SPA, the team will minimally consist of a Master Team Coordinator who will serve as the central coordinator for health home services, Psychiatrist, Registered Nurse, MA Level Clinician, CPST Specialist/Hospital Liaison, Peer Specialist, and other optional team members.
- Rhode Island augments the current CPST services to make sure it meets requirements.
- Rhode Island refers to payment as monthly case rate (flat rate) but same as PMPM as Missouri.
- Average team would serve 200 consumers. 11.25 FTEs team members constitute a unit of payment for reimbursement.

Discussion ensued with the following highlights/clarification:

- As some CPST services overlapped with Health Home services, it is very important for us to identify these services to make sure there are no duplicate payments and services.
- CMS is offering flexibility in reimbursement. They want to see a demonstration in how the flexibility in payments and services could have a positive impact.

**HEALTH HOME SERVICE DEFINITIONS:**

The draft Health Home service definitions were reviewed by the group and the finalized service definitions will be used in general throughout the health homes in Ohio. Ms. Kilinc provided an overview of the key service areas:

- Comprehensive Care Management – the process is 1) identify consumers who are eligible for health home services, 2) conduct comprehensive health assessment, 3) develop an integrated comprehensive treatment plan, 4) Form a health care professional team based on the individual's needs, and 5) Identify providers and develop a crisis management plan.
- Care Coordination – implement individualized care treatment plan, assist consumer in obtaining health care, medication management/monitoring, track tests and referrals and follow up, monitor care treatment, reassess the consumer at least once every 90 days.
- Health Promotion – provide education for individual's needs and provide tool/assistant for consumers to prevent health problems.
- Transition of Care – transition into community basis services
- Individual and Family Supports – building support system and educate individual and family as they deal with chronic conditions.
- Referrals to Community and Social Supports – facilitate referral and linkage services.

Discussion ensued with the following highlights/clarification:

- Health Information Technology (HIT) enables health home services. There is work to be

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done at the state level in order to implement.

- It might seem redundant across the six health home services components – they are not mutually exclusive, they are built from each other. It is constructed in a manner to allow the states to develop the basis for performing these service components.
- These health home service definitions will be a standardized and unified definitions for all the health homes in Ohio, will be applicable for primary care sites as well as behavioral health sites.
- Health Home service is bigger than CPST service. There are some overlaps between the two services. CPST has some components that are not health home, and health home has some components that are not CPST.
- The conducted comprehensive health assessment under Comprehensive Care Management service area does not replace diagnosis assessment nor replace physical assessment. It would be beneficial for CMHCS to take advantage of the information gathered from the primary care office, and then establish a treatment plan for individual consumer.
- It would be important to clarify and have a clear language about the assessment service in the Service Definition when State submits the SPA.
- CMHCs will be able to access health information exchange system in the future. The anticipated first rollout will be for hospital system sometime this year. It will be around summer 2012 for individual health care providers.

**MEDICAID MANAGED CARE PLAN**

Mr. Barley shared that:

- Managed Care Plans will be performing administrative functions. One of the functions would be to use medical informatics to view a client's claims and produce a detailed patient summary, and then provide these information to the team that is working on an individual's case.
- For people who are not enrolled in a Managed Care Plan, the plans will still be able to get data from ODJFS and use the same tool to produce summaries.
- Community Mental Health Providers do not have to be in the Managed Care Plan network to receive administrative functions.
- If an individual is enrolled in the Health Home, Managed Care Plan Care Manager can come in to fill the gap on a case by case basis, without duplication of services and payments.

**OHIO MEDICAID HEALTH HOME FOR BENEFICIARIES WITH SPMI – TEAM COMPOSITION:**

The above document was reviewed by the group. Discussion ensued and summary is below:

- In order to achieve meaningful outcomes, the goal needs to be clear and it is important to find a balance between productivity and quality.
- State is working with the actuary to develop the PMPM rate.
- Peer Specialist would be able to engage with consumers to provider peer support and be recovery driven. Consumers are empowered by the Wellness Management Recovery (WMR) model. Per SAMHSA guidelines, it would be necessary for the group to come up with an approach to address peer support model.
- Teams should be as small as possible and there should be a limit on the number of

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patients a team should handle so the team can consider the complexity of needs and risk of each consumer.

- It was suggested that Peer Support Worker and Pharmacist should be part of the team composition. State is looking into billable services for peer support and funding sources.
- Based on the caseload, regular meetings and electronic communications are both needed for team communication. The documentation and reporting system should be consistent. The consistent and clear goals could also improve communications among team members. Clear goals can keep team focus and unify the team.
- Have the team be part of the hiring process can help find people with good chemistry. Social Workers play an important role to develop the team at Southeast, Inc.
- Separate disciplines from functions when plan team composition. Within scope of practice it is important to recognize functions.
- The health home team will not be all of the primary providers together. The embedded primary care clinician in the health home will be the advocate and communication liaison and does not replace community primary care providers or specialty providers.
- The staffing summary worksheet presented is a good start. It is important to have some flexibility for negotiations when planning the core components.
- Spell out a high level of what a health home must do but allow regions to be innovative and give opportunities for flexibility so we are in a better position to describe what works.
- Health home team leader should be an independent clinician, master level with significant supervision experience.
- Care Manager Position should be minimum four-year degree. Managed Care Plan will pay for Care Manager Position.
- It was suggested to look at licensure rather than education level for Health Home Team Leader.
- The functions and services provided by peer support specialist should be clarified. It was recommended to use the State Hospital peer support specialist model.
- ODMH Research Office will perform a study on Health Home once the program is launched.
- Health Homes should be able to coordinate with different type of Specialists for consumers.
- Health Homes payments only cover the above mentioned 6 service areas. Does not cover purchased equipment.

**NEXT STEPS:**

- The Team Composition document will be revised based on feedback received. The revised version will be sent to the group to review.
- The staffing worksheet template will be modified to make sure the team composition, number of FTEs, etc. work right mathematically knowing it will vary regionally. Caseload assumption should also be made. Number of clients served (Team Caseload) will also be added to the staffing worksheet template. The categorization of FTEs should be consistent, i.e. RN/LPN for nurses, etc.
- The one pager distributed at the "kick-off" meeting will be revised based on the recommendation received and will eventually become the white paper.

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Recommendations will also be incorporated into the draft State Plan Amendment and will be shared with the group.

- If anybody has any additional recommendations and/or questions, please email Angie Bergefurd ([Angie.Bergefurd@mh.ohio.gov](mailto:Angie.Bergefurd@mh.ohio.gov)) and Afet Kilinc ([Afet.Kilinc@mh.ohio.gov](mailto:Afet.Kilinc@mh.ohio.gov)).
- State is currently working on developing case scenarios that will illustrate how Health Homes will work. These scenarios will also be shared with the group.
- Distribute the PowerPoint handout from the kick-off meeting to the group.

